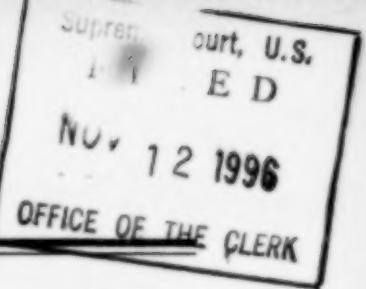


No. 95-1858

No. 96-110



In The

Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York;
GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D.,
and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
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BRIEF AMICUS CURIAE OF
THE AMERICAN COLLEGE OF LEGAL MEDICINE

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56 pp

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INTEREST OF THE AMICUS

The American College of Legal Medicine ("ACLM") respectfully submits this brief as an *amicus curiae* pursuant to Rule 37 of the Rules of the Supreme Court of the United States, and submits it in each of these cases. ACLM's position in this brief directly supports neither the petitioners nor the respondents in either case, instead advocating a neutral position that ACLM believes would best achieve the optimal outcome in these cases. ACLM has received the consent of all parties to submit this brief pursuant to the applicable rules of this Court. See Appendix A.

Founded in 1960, ACLM is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of about 1300 professionals, including physicians and scientists in most every specialty, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM is officially recognized by the American Medical Association ("AMA") as the society that represents legal and medical specialists, and ACLM holds a seat in the AMA House of Delegates.

ACLM's interest in these cases derives from the current prominence of the issue commonly known as physician-assisted suicide, coupled with a fear that advocates of each of the polar positions on this divisive issue fail to adequately appreciate the merits of the other. ACLM's interest is additionally driven by the fact that the aging of the "baby-boomer" generation will force an increasing number of individuals into end-of-life treatment decisions, particularly as continued advances in medical science enable physicians to prolong life notwithstanding the quality of that life. ACLM believes that, ideally, law and policy ought to amalgamate the most significant concerns on each side of this issue, in a manner that responsibly and pragmatically accounts for society's traditional abhorrence of suicide, without sacrificing the interests of those who endure the unfathomable pain and suffering often associated with the end-stages of terminal

illnesses. ACLM asserts that there is a middle-ground that will both protect the state's and society's interest in promoting and preserving meaningful life, and serve the interests of those who are some of the most desperate individuals in our society. Importantly, ACLM respectfully submits that this Court can reach such a balance within a constitutional framework premised upon its past decisions.

SUMMARY OF THE ARGUMENT

ACLM believes that a mentally-competent adult in the end-stages of a terminal illness owns the right to control end-of-life medical treatment decisions, such as refusing and terminating unwanted medical treatment -- a right recognized and protected by this Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). ACLM urges this Court to interpret end-of-life treatment decisions for such patients to include the right to obtain treatment intended to end life.

ACLM recognizes, however, that the state and society have a legitimate and compelling interest in ensuring that the right to control end-of-life treatment decisions is not abused by patients, their physicians and families, or interested third-parties. To protect against such abuse, ACLM believes it essential to regulate, through protocols, the administration of treatment intended to end life. Paramount, too, is strict enforcement of these protocols, through means to be established by the states in collaboration with the healthcare community.

ACLM's position is premised necessarily on the efficacy of these protocols. In this regard, ACLM presents to this Court for its consideration a compilation of the many varieties of healthcare-related regulations and protocols already in place. The benefits of consideration of these protocols are three-fold: First, it demonstrates that comprehensive regulations on end-of-life medical treatment imposed by

federal and state statutes, as well as by the healthcare community itself, not only exist, but also have effectively allowed for the responsible administration of end-of-life treatment and care. Second, many of these regulations in their current form would apply to the specific treatment at issue in these cases, *i.e.*, treatment intended to end life. Third, to the extent that existing regulations would not apply to the treatment at issue here, the regulations nevertheless provide a framework upon which applicable restrictions can and should be crafted.

Finally, ACLM acknowledges the context in which the instant issue arises, *i.e.*, a challenge to the constitutionality of statutes criminalizing physician treatment intended to end life. ACLM demonstrates herein that the right it asks this Court to recognize in no way constitutes a radical expansion of the rights already secured by our Constitution, but rather is consistent with Fourteenth Amendment rights that already have been recognized by this Court.

ARGUMENT

I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leave my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know that if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.

Seneca
Roman Orator
circa 3 B.C. - A.D. 65

I. The Right of Mentally-Competent Adults in the End-Stages of a Terminal Illness To Obtain Medical Treatment Intended To End Life Is Essential to Preserve Human Dignity in Dying.

The issue in these cases -- whether a mentally-competent adult in the end-stages of a terminal illness has a right to medical treatment intended to end life -- creates virulent debate and a division in public opinion equaled by few, if any, other issues of the day; the debate and division, however, are understandable. Proponents on one side argue that what is at stake is perhaps the most fundamental right known to humankind -- the right to control one's body and life; advocates on the other side equate the acts at issue here to suicide by the patient, and to killing by the physician. For this reason, ACLM urges this Court to focus not only upon the constitutional analysis, as of course it must, but also upon the consequences and policy implications of a decision premised upon that analysis.

A. The Term "Physician-Assisted Suicide" Colors The Issue.

Semantics, of course, do not resolve the instant issue. Yet, the term "physician-assisted suicide" is arguably a misnomer that unfairly colors the issue, and for some, evokes feelings of repugnance and immorality. The appropriateness of the term is doubtful in several respects. First, neither the New York nor the Washington statute at issue in these cases contain the phrase "physician-assisted suicide." See N.Y. Penal Law §125.15(3) (McKinney 1987); Wash.Rev.Code §9A.36.060 (1980). Second, the word "suicide" itself is defined not only as the "taking of one's own life" but also as the "destruction or ruin of one's own interests." *Webster's Third New International Dictionary*, 2286 (1981). As exemplified in the discussion below, it seems inappropriate to characterize requests for treatment that ends life, made by suffering, terminally-ill patients, as any form of destruction or

ruination of their interests. Assuming a patient's mental competence, and recognizing this Court's long-held commitment to the principles of personal autonomy and free will (see, e.g., *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847, 851 (1992) (both quoted *infra*)), prescribing medication intended to end life in the subject context *serves* -- not destroys or ruins -- a patient's interests. For these reasons, ACLM questions whether the subject statutes even apply to the situation in which a physician cares for a mentally-competent adult in the end-stages of a terminal illness with medical treatment intended to end life. Notwithstanding that fact, ACLM rejects the term "physician-assisted suicide," and instead refers herein to the practice in question as "treatment intended to end life."

B. Individual Patient's Conditions Demonstrate That Treatment Intended To End Life Can Be Essential To Dying With Dignity.

In forming policy on this issue, it is critically important to consider the horrific situation in which, unfortunately, innumerable patients find themselves. These patients' individual stories enlighten us to the experience of dying a slow, painful and agonizing death. Consider the following:

Jane Doe was a mentally-competent adult in the end-stage of cancer. She endured a cancerous tumor that had wrapped around her right carotid artery, collapsing her esophagus and invading her voice box. The tumor restricted her ability to swallow and prevented her from eating anything but very thin liquids in extremely small amounts. Eventually, she was placed on a feeding tube, which caused serious additional medical problems.

Quill v. Vacco, 80 F.3d 716, 720 (2d Cir. 1996); see also *Cruzan*, 497 U.S. 261, 289 (O'Connor, J., concurring)

("[b]ecause of the discomfort such a [feeding] tube causes, [m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube" (citation omitted)).

William A. Barth was a mentally-competent adult in the end-stage of AIDS, who had endured years of radiation and chemotherapy treatment for cancer. As a result of AIDS, he contracted (a) cytomegalovirus in his stomach and colon which caused severe diarrhea, fevers and wasting; (b) a type of parasitic infection which independently caused severe diarrhea, extreme abdominal pain, nausea and additional significant wasting; (c) another type of parasitic infection for which there was no treatment; and (d) pneumonia, for which he regularly took infusion therapy treatment that was so toxic he vomited with each infusion.

Quill, 80 F.3d 716, 720.

These are the histories of just two of the plaintiffs in these cases, each of whom filed their lawsuit asserting a right to care and treatment to end life, and each of whom has died from disease during the pendency of these cases. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 795 (9th Cir. 1996); *Quill*, 80 F.3d at 722. Repeating these stories is essential to recognizing an inescapable conclusion: Individuals who seek care and treatment intended to end life include human beings who suffer a torturous existence. Notwithstanding the impact of descriptive language that ingrains these patients' suffering, the extent of their misery is, by its nature, beyond the comprehension of anyone not in their position. While these stories surely evoke feelings of compassion, no one should pretend to know definitively whether he or she would desire life-ending care and treatment in a like situation. Moreover, from these patients' situations, we also understand that they suffered excruciating pain beyond

the bounds of non-lethal doses of pain medication, and further, that they endured the indignities that come with failing bodies. For each, death was imminent and certain, but for each, every moment of that existence was torturous.

It is also significant to realize that these histories are not a few isolated situations, which, for better or worse, are mooted by these patients' respective deaths. The average age of the population of the United States is rising, while at the same time, advances in medical science enable physicians to maintain life long beyond the stage at which fatal disease causes physical incapacitation and unendurable pain. As Professor George P. Smith II noted,

Life is not an amaranth, the imaginary flower that never fades. For all too many, the "benefits" of modern medicine and treatment extend the fading process with tragic withering, discoloration and odor.

Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?* 22 U.C. Davis L.Rev. 275, 281 (1989) ("Smith"). Without life-ending treatment, a mentally-competent patient in the end-stages of a terminal illness is left with an option of a conscious existence that is excruciatingly painful and devoid of dignity, or alternatively, medications that diminish or end consciousness, thereby rendering continued life meaningless. ACLM respectfully submits that, in a free, humane and civil society, this is no option at all. For patients in this condition, the right to care and treatment intended to end life is necessary to avoid pointless suffering and maintain personal dignity in the final phase of their life.

C. Protocols Will Offset The Potential For Abuse

As the Ninth Circuit aptly noted in its decision on appeal, "[r]ecognition of any right creates the possibility of abuse."

Compassion in Dying, 79 F.2d at 831. Indeed, the state has a legitimate and compelling interest to ensure that the right to control end-of-life treatment decisions is not abused by patients, their physicians and families, or interested third-parties. But, as this Court recognized in *Cruzan*, where such potential for abuse exists, the state simply must "guard against potential abuses." 497 U.S. 261, 281.

ACLM agrees. To avoid abuses, it is incumbent upon government in collaboration with the healthcare community to establish regulations on the administration of treatment intended to end life. As shown in greater detail *infra*, there are abundant mechanisms in existence today which serve to regulate healthcare and treatment -- some in the form of federal and state legislation, and many in the form of protocols established by the healthcare community itself.

Critical, too, is the enforcement of these statutes, regulations and protocols. For example, "[i]f an individual [physician] abuses the privilege of exercising proper medical judgment" in administering treatment intended to end life, "the usual remedies, judicial and intra-professional, are available." *Roe v. Wade*, 410 U.S. 113, 167 (1973).

Which regulatory mechanisms, protocols and associated penalties will most successfully avoid abuses in the context of the right at issue here is best-determined through the collaborative initiatives of the state and the healthcare community. Obviously, penalties for any violation of law, regulation or protocol should be commensurate with the seriousness of the offense. And although this Court's decision in *Cruzan*, too, recognized a right which seemed wrought with the potential for abuse, this Court expressed its justified confidence in the ability of states and the healthcare community to craft appropriate regulations:

Today we decide only that one State's practice does not violate the Constitution; the more challenging

task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States....

Cruzan, 497 U.S. 261, 292 (citation omitted). As shown *infra*, states and the healthcare community have responded impressively with respect to regulating the withdrawal of life-support systems. Contrary to the early critics of *Cruzan*, since this Court rendered its decision in that case, there has *not* been a public outcry of abuse, nor do we hear of utilizing *Cruzan* to endanger the elderly, infirm, disabled and indigent. This oft-heard slippery slope argument is unfounded due to the substantiated fact that the states and the healthcare community possess the skill and know-how to manage and administer end-of-life treatment decisions. Simply stated, the slippery slope proved to be nothing but an imaginary hill. Moreover, to doubt now the collective wisdom of the states and healthcare community would be to reject the premise of this Court's holdings in *Roe v. Wade*, *Cruzan* and *Casey*.

II. End-Of-Life Decisions Should Follow Protocols Intended To Respect The Dignity Of Patients And The Sanctity Of The Patient-Physician Relationship.

As a result of the "growing medicalization of death" (Smith, *supra* at 359; see also Quill, *et al.*, *Care of the Hopelessly Ill - Proposed Clinical Criteria*, 327 N.Eng.J.Med. 1380 (1992)), the responsibility of the healthcare community in this era of medical technology is profound and daunting. The most sacred patient-physician relationship, once established and seen as a collaborative effort, should not be forced to end at a time when an individual's values and integrity are at their most critical juncture. The physician's ability to care for a patient is at no time more meaningful than when the doctor affirms the dignity of the patient through assistance in end-of-life treatment decisions.

ACLM, however, advocates that a physician assist a patient in end-of-life treatment decisions only through the use of strict protocols, intended to evaluate a patient's medical, physical, emotional, psychological and social state of being. Prior to the administration of any treatment intended to end life, a physician should be required to thoroughly discuss all medical options available to the patient, if any, including palliative care. ACLM, too, is cognizant of, and concerned over, the potential abuse of the elderly, infirm and indigent arising out of end-of-life treatment decisions. To date, however, existing protocols regarding the termination or withdrawal of life-sustaining treatment have vastly decreased the possibility of such abuse.

For example, federal and state advance directive statutes are prevalent throughout the country, and they assist individuals in documenting and implementing their end-of-life decisions.¹ As of March, 1996, for instance, almost every state authorizes either living wills or the appointment of a healthcare agent, or both.² See *Choice In Dying, Diagram of State Statutes Governing Living Wills and Appointment of Healthcare Agents* (1996) (Appendix B). In order to implement these advance directives, healthcare facilities

1 An Advance Directive is an "explicit statement by a decisionally-capable adult, either written or communicated orally, that states preference for medical care in the future if the person should no longer be able to consider the medical options and communicate a preference. Dubler and Marcus, *Mediating Bioethical Disputes* 77 (1994).

2 A living will relating to the use of life sustaining treatment specifies under what medical conditions a physician is instructed by a patient to withhold or withdraw treatment. Such conditions usually include an incurable and irreversible condition that without the administration of life-sustaining treatment, would cause the death of a patient.

A health care agent also referred to as an attorney-in-fact, judicially appointed guardian or a power of attorney for healthcare, is an individual appointed by the patient to make decisions on the patient's behalf regarding the withholding or withdrawal of life-sustaining treatment whenever the patient is no longer capable of making his or her own treatment decisions.

employ protocols and ethics committees³ that enable medical and nursing staff to comply with patients' pre-determined medical treatment decisions.

The existence of such advance directives and protocols to implement them is more important than ever before.⁴ It is estimated that, by 2050, over 20% of our population will have reached the age of 65 or older (compared to 4% in the early 1900's). Cohen, *Realism, Law and Aging*, 18 Law, Medicine and Health Care 183, 189 (Fall 1990) (citing Spencer, U.S. Bureau of the Census, *Projections of the Populations of the United States by Age, Sex, and Race: 1983-2080*, in *Current Population Reports*, Series P-25 No. 952 (Mar. 1984)). Moreover, the number of individuals over 85 living in nursing homes will increase from 22% in 1985 to triple that number in 2010 (Cohen, *supra* at 189, citing *Aging Americana: Trends and Projections*, 1987-1988 U.S. Senate Special Comm. on Aging, p. 118), many of whom may be suffering from Alzheimer's Disease. *Id.*, citing Evans, *et al.*, *Clinically Diagnosed Alzheimer's Disease: An Epidemiological Study in Community Population of Older Persons*, 262 JAMA, 2551-2556 (1989). "Baby-boomers" who are currently debating the issue of end-of-life treatment decisions will be faced with this very issue within the next twenty to fifty years. Treatment decisions to end life will no longer be legal and medical issues as much as they will be societal issues — issues that must be confronted, and these cases provide for this opportunity.

3 An ethics committee is a "[c]onsultative committee in a hospital or other institution whose role is to analyze ethical dilemmas and to advise and educate health care providers, patients and families regarding difficult treatment decisions", including end-of-life decisions. Dubler & Marcus *supra* at 79; see also Hastings Center, *Guidelines on Termination of Life Sustaining Treatment and the Care of the Dying*, *supra*, 100-105 (1987).

4 A recent study confirmed that patients suffering from a terminal illness frequently contemplate end-of-life medical treatment issues. Emanuel, *et al.*, *Euthanasia and Physician Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public*, 347 Lancet 1805-10 (1996).

A. The Patient Self-Determination Act Proves That Advance Directives Are An Effective Means To Express Patients' Treatment Decisions.

In response to *Cruzan*, the legal community in collaboration with healthcare experts created and enacted the Patient Self-Determination Act ("PSDA") (42 U.S.C. §1395 cc(f) (West 1992 & Supp. 1996)). Since its enactment, the PSDA has served as the procedural linchpin upon which healthcare institutions, physicians and patients currently rely with respect to end-of-life treatment options and decisions. The PSDA requires *all* hospitals, skilled nursing facilities, home health agencies, hospital programs and health maintenance organizations (HMOs), that receive Medicare or Medicaid funding, to educate patients about advance directives. Specifically, healthcare facilities must provide patients, upon admission, with information regarding their state-law rights regarding end-of-life decisions, including the right to refuse or accept any form of medical treatment, and the right to exercise an advance directive (if one has not already been prepared). Whether the patient has executed an advance directive must be documented in the patient's medical chart to ensure compliance with the patient's direction. Patients are not required to execute advance directives, and their medical care is in no way conditioned upon their execution of one. The PSDA also recognizes that, for moral, ethical or religious reasons, medical institutions or medical staff may not be willing to comply with any particular form of treatment set forth in an advance directive. The PSDA, therefore, requires that patients be notified of these beliefs.

Furthermore, the PSDA requires that institutional staff, as well as the community at large, be provided with information regarding advance directives. This aspect of the PSDA is critical if patients, families, healthcare institutions and communities are to understand the impact advance directives can have on individuals, and on society as a whole.

ACLM believes that the PSDA should be applicable to all end-of-life treatment decisions, including treatment intended to end life.

B. Healthcare Institutions Use Protocols That Promote Compliance With Patients' Treatment Decisions, And Committees That Assist In The Resolution Of Bioethical Disputes.

For decades, healthcare institutions have taken a leading role in recognizing and lending support to patient decision-making. For instance, hospitals have established policies that assist medical staff in determining a patient's decision-making capacity, including a patient's ability to make end-of-life treatment choices. Similarly, the American Hospital Association's *Policy and Statement on Patient's Choice of Treatment Options* (1985) (see Appendix C) provides that "[h]ealth care decision making should be based on a collaborative relationship between the patient and the physician" and that "institutional methods should be established to reasonably assure that the patient may exercise this authority on the basis of relevant information necessary to make a sufficient voluntary and informed decision." This policy also provides safeguards whereby patients can make decisions regarding the withholding and withdrawal of medical treatment.

Furthermore, the Joint Commission on Accreditation of Health Care Organizations ("JCAHO"),⁵ and by reference, the federal Medicare program, has set standards to assist healthcare facilities in creating and implementing policies and procedures with respect to obtaining a patient's informed

⁵ JCAHO is a private, voluntary accrediting organization, the principle roles of which include establishing standards for the operation of healthcare facilities, recognizing compliance with these standards through issuance of certificates of accreditation, and conducting surveys and accreditation programs that encourage and assist such facilities in promoting efficient, high-quality patient care.

consent to treatment. JCAHO, *Comprehensive Accreditation Manual for Hospitals, Patient Rights and Organization Ethics*, RJ 1.2.1 (1996). Pursuant to these standards, the ability of a patient to provide informed consent is conditioned upon the following factors: a patient must (1) have the capacity to make reasonable judgments; (2) have a clear understanding of the nature of his or her disease and prognosis, as well as an understanding of the risks and benefits associated with proposed treatment alternatives; and, (3) make decisions voluntarily and without any degree of coercion. Appelbaum and Gisso, *Assessing Patients' Capacity to Consent to Treatment*, 319 N.Eng.J.Med. 1635-1638 (1988).

Particularly relevant to the instant issue is a physician's ability to determine a patient's capacity to give informed consent where that patient suffers excruciating pain, dementia or depression. In order to gauge a patient's true desires on treatment, healthcare facilities employ the use of specialists, including pain-management specialists, gerontologists, psychiatrists and oncologists. Gordon and Linger, *Decisions and Care at the End of Life*, 346 Lancet 163-66 (1995).

Physicians who treat terminally-ill patients also consult with specialists knowledgeable in the use of palliative care, also known as "comfort care." "Palliative care" refers to medical, surgical and other interventions designed to alleviate "suffering, discomfort and dysfunction, whether physical or not, but not to cure". Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 141 (1987); see also, *Id.*, 73-75 ("Since patients know most fully the extent of their suffering and their need for relief, their wishes about palliative care and pain relief should guide professionals. Whenever possible, the patient, together with the responsible healthcare professional, should determine the degree and type of palliative and pain relief...."). Palliative care is utilized most often in hospice programs. The goal of this type of care is to relieve the patient's symptoms, and ease the process of dying by providing care and support

that enhance the quality and meaning of the patients' remaining life...." Miller et al., *Regulating Physician-Assisted Death*, 331 N.Eng.J.Med. 119 (1994).

Although some express concern over the ability of infirm and elderly patients to fully-comprehend treatment options and the impact of their treatment decisions, a comprehensive study has shown that such patients, in fact, do understand healthcare information, and that they are capable of making decisions regarding advance directives, through the use of simplified story books and discussion paralleling the patient's level of comprehension. Drynski, et al, *How Informed Can Consent Be? New Light on Comprehension Among Elderly People Making Decisions About Enteral Tube Feeding*, 34 The Gerontologist 36-43 (1994).

Furthermore, several states, including California, require skilled nursing facility patients to execute advance directives in the presence of patient advocates or ombudspersons (designated by the state), who specialize in treating the aged and infirm. See, e.g., Cal. Health & Safety Code §7188 (West Supp. 1996). See also Ore.Rev.Stat. ch. 127.515(4)(e) (Supp. Part 2, 1994). This policy serves as yet another safeguard to the threat of abuse or coercion.

In fact, even prior to *Cruzan* and the PSDA, hospitals employed policies and procedures governing the acquisition of informed consent from the aged and infirm, and governing the withdrawal of life-sustaining treatment. Likewise, JCAHO, since January, 1988, has established hospital standards regarding the withholding and withdrawal of resuscitative services and life-sustaining treatment.

As these issues became more complex, hospitals began to address the moral, ethical and religious concerns relating to a patient's decision either to withdraw or forego treatment. Again, the healthcare community addressed this new-found problem effectively. Ethics committees were developed to

assist medical staff and patients in resolving these moral, ethical and religious conflicts arising out of a patient's treatment decisions. See, e.g., Osborne, *Physician Decisions Regarding Life Support in the Intensive Care Unit; Ethics in Cardiopulmonary Medicine*, 101 Chest 135-145 (1992). Ethics committees became widely utilized after JCAHO published standards for hospitals regarding the recognition of bioethical disputes and establishment of policies and procedures to resolve these conflicts. JCAHO, *Comprehensive Accreditation Manual for Hospitals, Patient Rights and Organization Ethics*, RI 1.2.3 at 76 (1996).

Depending on the milieu of an institution, ethics committees serve a variety of functions, including, (a) reviewing a patient's case to confirm that individual's diagnosis and prognosis; (b) providing a forum for discussing broader social and ethical concerns raised by a particular case; (c) educating professional staff how to identify, frame and resolve ethical problems; (d) formulating policy and guidelines regarding such decisions; and (e) reviewing decisions made by others (such as physicians and surrogates) about the treatment of specific patients or make such decisions themselves. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life Sustaining Treatment*, 160 (1983).

Cutting-edge innovative programs have also assisted hospitals and bioethics committees in mediating bioethical disputes and training hospital staff to facilitate resolution of disagreements among patients, family and medical staff. For example, the Center for Medical Ethics and Mediation, located in San Diego, California, currently teaches healthcare professionals and staff in hospitals and managed care facilities the theory and skills utilized in mediation of bioethical and health law disputes arising between medical staff and patients. The Center for Medical Ethics and Mediation, *Kaiser Permanente Re-engineers for Conflict-Positive Customer Relations*, 4 Pontis 1 (Spring 1996). Similarly, the Program

for Health Care Negotiation and Conflict Resolution at the Boston University School of Public Health collaborated with Montefiori Medical Center in New York to create a prototype of alternative dispute resolution techniques, particularly mediation, that could be used to resolve bioethical disputes in the hospital setting. Dubler & Marcus, *Mediating Bioethical Disputes*, 1994.

In response to the recognized need to educate physicians and healthcare practitioners regarding palliative and life-ending medical treatment,⁶ palliative-care committees serve as an example of overseeing treatment decisions intended to end life. These committees, composed of lay members and professionals, "would be responsible for educating clinicians and the public about methods of comfort care (including pain management), ethical standards of informed refusal and discontinuation of life-sustaining treatment and the option of physician assisted death." Miller, *et al.*, *Regulating Physician Assisted Death*, 331 N.Eng.J.Med. 119, 121 (1994).

C. The Uniform Rights of the Terminally Ill Act And The Uniform Health Care Decisions Act Effectively Regulate Treatment Decision-Making.

As stated, *supra*, the 1970's and 1980's saw a flurry of activity as states attempted to create advance directive statutes that recognized the need of their citizens to personally control their healthcare decision-making.

The increasing interest in advance directives served as a catalyst for the National Conference of Commissioners on Uniform State Laws ("Commissioners") to draft and approve

⁶ According to a 1992-93 survey conducted by the American Medical Association, of the nation's 126 medical schools, only five have a required course on the care of dying patients. Gordon, *Perspective on Assisted Suicide: Doctors are Remiss at the Death Bed*; L.A. Times, Oct. 10, 1996 at B9.

the 1985 Uniform Rights of Terminally Ill Act ("Act") in 1985. 9B U.L.A. 609 (1987). Although the Act drew upon existing legislation, the Commissioners drafted language that was "simple, effective, and acceptable to those individuals desiring to execute a declaration and to physicians and health care facilities whose conduct [would] be affected." The Act was crafted to avoid statutory inconsistencies that characterized earlier statutes and provided that advance directives executed in one state would be reciprocally recognized in other states. *Id.* Various states have adopted some form of living will or advance directive based upon the model Act.

By 1993, as a result of *Cruzan*, the Commissioners created the Uniform Health Care Decisions Act, ("Health Care Decision Act"), which effectively superseded the Act. 9 U.L.A. 220 (1996). The intention of the drafters of the Health Care Decisions Act was to "pave a health care decisionmaking superhighway." C. Sabatino, *Symposium: Trends in Health Care Decisionmaking, Etc.*, 53 Md.L.Rev. 1238-1239 (1994). The Commissioners deleted such "preconditions such as certification of diagnosis of a terminal condition or permanent unconsciousness, the need for life-sustaining procedures, and special needs for nutrition and hydration or pregnancy." *Id.* In fact, the Health Care Decision Act not only includes language regarding advance directives, it includes all medical decisionmaking even if an advance directive is not executed. The patient may also designate a healthcare agent to make any treatment decisions for the incapacitated patient. Health Care Decision Act, 7(b). Further, recognizing the vulnerability of patients confined to long-term residential healthcare facilities, the Health Care Decisions Act precludes owners, operators or employees of such facilities from serving as agents unless they are related to the resident by blood, marriage or adoption. *Id.* at §2(b). With respect to the validity of sister-state advance directives, the Health care Decisions Act simply states that if an advance

directive complied with the Health Care Decisions Act, it is valid regardless where it was executed. *Id.* at §2(h).

The Commission's approach makes an important point: the autonomy of the patient and the patient's ability to communicate with his or her doctor and any health care decisions made as a result of this communication must be honored. The Commissioners also serve as an example to this Court where one body, expert in the area of advance directives, can draft model legislation that can serve as a template for individual state legislatures.

D. The Oregon Death With Dignity Act And The Australian Rights Of The Terminally Ill Act Are Examples Of Existing Legislation On This Issue.

Currently, few statutes anywhere in the world specifically authorize physicians to assist patients in ending their lives. Two of these statutes are the Oregon Death With Dignity Act, Ore.Rev.Stat. ch. 127.800 §1.01 *et seq.* (1995) ("Oregon Act"), and the Northern Territory of Australia Rights of the Terminally Ill Act ("Australian Act"). Each provides substantial protection for patients and physicians.

The Oregon Act, passed in November 8, 1994, is the first American statute permitting and regulating treatment intended to end life.⁷ The Oregon Act provides, *inter alia*, that (i) a witness to any advance directive regarding end-of-life treatment, executed by a patient in a long-term facility, must be an "individual designated by the facility [who] has the qualifications specified by the Department of Human Resources;" (ii) patients must be made aware of feasible alternatives including comfort care, hospice care and pain

⁷ In *Lee v State*, 86 F.Supp. 1491, 1493 (D.Or. 1994), the district court imposed a preliminary injunction, ruling that substantial constitutional issues need be resolved before the Oregon Act may be implemented. This statute, nonetheless, provides an interesting model for the regulation of treatment intended to end life.

control; and (iii) if a physician believes that the patient is suffering from a psychiatric or psychological condition or depression impairing the patient's judgment, the physician shall request that the patient be referred to counseling. Ore.Rev.Stat. ch. 127.810 §2.02(4); ch. 127.815 §301(e); and ch. 127.875 §303 (1995). The Oregon Act, however, fails to address the use of ethics/oversight committees specializing in the treatment of terminally-ill patients -- a proposal that ACLM feels is vitally important.

The Australian Act, on the other hand, is significantly more comprehensive. Under the Australian Act: (1) palliative care options must be made available to the patient, and if this care can bring about a remission in the patient's pain and suffering, the physician shall not assist the patient in ending life; (2) medical treatment is to be confined to the relief of pain and suffering, with the object of allowing the patient to die comfortably; (3) two additional physicians, other than the primary physician, one being a psychiatrist, must examine the patient to determine that the patient's request is not premised upon treatable clinical depression; (4) the physician must be satisfied that the patient has made an informed decisions and has not been coerced to end life; (5) at least 48 hours must elapse between the time the patient requests and the physician provides treatment that will hasten the patient's death; and, (6) the physician must be guided by appropriate medical standards and pharmacological guidelines, and the physician must remain with the patient while assistance is given, and until the death of the patient.

Debate over the Australian statute is far from over. Australia's legislature is now considering a bill entitled *Care of the Dying Consultation Bill*, which would create a committee designed to address the following issues: (a) the extent to which both the health services and the present law provide adequate options for dying with dignity; (b) whether there is sufficient public and professional awareness of pain relief and palliative care available to persons facing prolonged

pain in a terminal illness; (c) whether there is adequate provisions of pain relief and palliative services to persons facing prolonged pain in a terminal illness; (d) whether there is sufficient public and professional awareness of the [country's] *National Death Act* and, if not, what measures should be taken to overcome any deficiency; (e) to what extent, if any, community attitudes towards death and dying may be changing; and (f) to what extent, if any, the law relating to dying needs to be clarified or amended. See *Northern Territory of Australia, Care of the Dying Consultation Bill* (1996).

ACLM believes that regulations regarding treatment decisions intended to end life cannot exist without a structure that has the ability to oversee and evaluate the treatment process, as well as to provide for extensive education of the public regarding the options available to terminally ill patients. Clearly, discussions regarding legal and public policy issues attendant to end-of-life treatment decisions will be ongoing. Nevertheless, the gauntlet is laid. Numerous comprehensive regulations on end-of-life medical treatment imposed by federal and state statutes, as well as by the healthcare community itself, not only exist, but also effectively allow for the responsible administration of end-of-life treatment and care. In fact, many of these regulations in their current form would apply to the specific treatment at issue in these cases, *i.e.*, treatment intended to end life. To the extent they would not so apply, these laws and protocols provide a framework upon which applicable regulations can and should be crafted.

III. The Right To Treatment Intended to End Life Is Consistent With Traditional Notions Of Liberty-Based Rights Secured By The Due Process Clause

In this appeal, petitioners challenge the Second and Ninth Circuit's rulings that the state statutes in question in each of these cases are unconstitutional. The Second Circuit found the New York statute unconstitutional on equal protection

grounds, whereas the Ninth Circuit invalidated the Washington statute as an impermissible deprivation of a patient's liberty rights, *i.e.*, substantive due process rights. As stated *supra*, ACLM questions whether these statutes -- which criminalize promoting or assisting in suicide -- even apply to the situation in which a physician provides treatment intended to end life for a mentally-competent adult in the end-stages of a terminal illness, because arguably, the act in question here is not suicide. Petitioners, however, clearly believe that it is. Assuming *arguendo* the accuracy of that position, ACLM asserts that patients fitting the qualifications repeated throughout this brief are constitutionally-entitled to seek treatment intended to end life under the due process clause of the Fourteenth Amendment. That right, however, like most all rights, is not absolute, and must be appropriately regulated to avoid abuse, particularly in light of the seriousness of abuse in this context, *i.e.*, the potential promotion of patient suicide. Accordingly, ACLM asserts that the subject statutes are unconstitutional *to the extent* that they criminalize, *per se*,⁸ treatment intended to end the life of a mentally-competent adult in the end-stages of a terminal illness.

A. The Supreme Court Has Long-Recognized An Individual's Right to Personal Autonomy and Bodily Integrity, Which Principles Underlie The Right Sought By Respondents.

ACLM's position is premised, certainly, upon its belief that the subject treatment should be available for "qualified" patients who seek it. But ACLM's position is also supported by, and consistent with, a long line of Supreme Court decisions which secure the rights of individuals to be free

⁸ ACLM does not contend that the subject statutes are unconstitutional to the extent that they criminalize promoting or assisting in suicide generally, but rather, ACLM asserts that they constitute an impermissible infringement on the rights of a mentally-competent adult in the end-stages of a terminal illness to seek from a physician medical treatment intended to end life.

from undue governmental intrusion in the most personal, intimate choices that go to the essence of personhood, personal autonomy and self-determination. For example, in 1891, the Supreme Court decreed that:

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891); see also Justice Benjamin Cardozo's opinion in *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

The venerable Justice Louis Brandeis echoed this principle nearly four decades later *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("[t]he makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness ... [t]hey sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations ... [t]hey conferred ... the right to be let alone -- the most comprehensive of rights and the rights most valued by civilized men").

As Justice O'Connor noted, concurring in *Cruzan*, "[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause." 497 U.S. 261, 287. Not only has this Court long-protected an individual's bodily integrity, it also has expressly (a) confirmed the existence of a right (based in Fourteenth Amendment liberty interests) of an individual to make life and death decisions, and (b) recognized the potential for abuse of

that right, acknowledging the need for appropriate state regulation:

The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe [the state] may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, "there will, of course, be some unfortunate situations in which family members will not act to protect a patient." A State is entitled to guard against potential abuses in such situations.

Cruzan, 497 U.S. 261, 281 (citations omitted).

Most recently, this Court articulated its respect for personal autonomy in making life's most personal decisions:

It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter. * * * * * These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 847, 851 (1992) (citations omitted).

There can be no decision in life more personal, more intimate, and more warranting of constitutional protection than that of a terminally-ill patient contemplating whether to live under the burden of disease, pain and indignities, or to accede to mortality when death is at the door. Moreover, this position is hardly unique to ACLM; it underlies each of the federal appellate decisions at issue here:

In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Quill, 80 F.3d at 727 (citation omitted).

[T]he decision how and when to die is one of "the most intimate and personal choices a person may make in a lifetime," a choice "central to personal dignity and autonomy." A competent terminally-ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.

Compassion in Dying, 79 F.3d at 813-814.

Under this weighty precedent, and under the language of the distinguished panels of the Second and Ninth Circuits, ACLM asserts that there is ample foundation on which to recognize and protect the liberty interests of a mentally-

competent adult in the end-stages of a terminal illness to obtain care and treatment intended to end life.

Finally, ACLM recognizes and supports the Second Circuit's decision in *Quill*, which, too, recognizes the constitutional right of "qualified" patients to seek medical treatment intended to end life -- a decision based on equal protection, rather than due process, grounds. The Second Circuit's decision, however, is squarely-premised upon its finding that there is no relevant distinction between the withdrawal or withholding of life-support systems and treatment with the intent to hasten death, on the one hand, and the administration of drugs with the intent to hasten death, on the other hand. While ACLM agrees, believing both acts to be medical treatment intended to end life, ACLM also recognizes that there is room for reasonable debate and disagreement with respect to that distinction. Because the right sought herein is fundamental to those principles of liberty secured under the Fourteenth Amendment, ACLM believes the right should be recognized under the Due Process Clause.

B. ACLM's Position Does Not Infringe Upon The Integrity Of The Medical Profession.

ACLM -- an organization led by and including numerous physicians -- asserts that its position in no way infringes upon the integrity of the medical profession. Those who argue otherwise, most notably the *Compassion in Dying* petitioners and the AMA, contend essentially that a physician is barred from assisting in the termination of life under any conditions due to his or her obligations imposed by the Hippocratic Oath. The Ninth Circuit cleanly disposed of this contention. Noting that the identical argument was asserted in *Roe v. Wade* and *Cruzan*, in opposition to the rights sought in those cases, the Ninth Circuit stated that the Oath was not even accepted by all physicians at the time it was created. 79 F.3d at 829. Moreover, the Oath hardly "represent[s] the best or final word

on medical or legal controversies today." *Id.* Finally, to impose upon American jurisprudence the dictates of the Oath would, arguably, not only preclude a physician, in all situations, from performing an abortion, from terminating life-support and from providing treatment intended to end life, it would furthermore preclude a physician from engaging in surgery. *Id.* Clearly, American law should not rely upon the Hippocratic Oath in constitutional interpretation.

Finally, ACLM fully acknowledges and supports an individual physician's right to decide whether to provide care and treatment intended to end life. The physician who finds religious, moral or ethical reasons not to provide such treatment certainly need not do so. ACLM asserts, however, that, as shown in *Roe* and *Cruzan*, this option of the individual physician should not bar "qualified" patients from exercising a constitutional right to seek such treatment.

C. The Treatment At Issue Here Is Consistent With Treatment Long-Provided By Physicians.

In *Compassion in Dying*, the State of Washington argued to the Ninth Circuit that it was appropriate to draw a distinction between, on the one hand, a physician prescribing medication for the *sole purpose* of hastening death -- behavior, the state argued, is and should be criminalized -- and on the other hand, a physician prescribing medication for the *dual purposes* of alleviating pain and hastening death -- behavior, the state argued, is appropriate and lawful. 79 F.3d at 823.

In this regard, ACLM confirms the Ninth Circuit's understanding that, for decades, physicians have routinely and openly provided medication to terminally-ill patients with the knowledge that the drug will have the dual effect of reducing pain and hastening death. 79 F.3d at 823. If, however, this practice is to remain lawful, as the State of Washington and the AMA argue it should, then it is wholly inconsistent to argue that "sole purpose" treatment must remain unlawful. It

defies logic to contend that the physician, who prescribes a drug that will alleviate pain and hasten death, is a merciful healer, while the physician, who prescribes a drug that will hasten death and thereby eliminate pain, is a punishable felon. See also 79 F.3d at 823 n. 95. Under common medical practice of the day, this inconsistent result would be realized by upholding the subject statutes in their entirety.

IV. Conclusion

ACLM began this brief with the words of Seneca uttered over twenty centuries ago. His words are prophetic and instructive, because he contemplates the instinctive zest for meaningful life, while acknowledging the pointless despair resulting from physical deterioration. Indeed, risks exist in recognizing the right of competent adults in the end-stages of a terminal illness to determine the time and manner of their death; but safeguards, crafted and imposed by government and by the healthcare community, will minimize the threat of abuse and assuage societal fears. With appropriate protocols, we must take and overcome these calculated risks to secure human dignity and personal autonomy in death. Sherwin B. Nuland, M.D., in his book, *How We Die* (Vintage 1995), ties this notion to the words of Seneca:

All of this is not to say that there are no situations in which Seneca's words deserve heeding. But should this be so, the Roman's doctrine would then deserve consultation, counsel, and the leavening influence of a long period of mature thought. A decision to end life must be as defensible to those whose respect we seek as it is to ourselves. Only when that criterion has been satisfied should anyone consider the finality of death.

Nuland at 152. Criteria and protocols are, indeed, the watchwords of the day.

Moreover, ACLM is mindful of the vast benefits of advancements in medicine and technology; but science not only prolongs life, it concomitantly prolongs misery, pain and suffering. With this in mind, we ought not be driven by medical advancement to the disregard for the rights of terminally-ill patients, such as those on whose behalf the instant cases were brought. ACLM recommends to this Court the Nuland book (*supra*), and especially the story of the final days, in 1961, in the life of Harvard Physicist and Nobel Laureate, Professor Percy Bridgman. A colleague remembers Bridgman, then suffering from terminal cancer, deploring the need to end his own without assistance:

I would like to take advantage of the situation in which I find myself to establish a general principle: namely, that when the ultimate end is as inevitable as it now appears to be, the individual has a right to ask his doctor to end it for him.

Nuland at 152-153. The message Seneca conveys and the words of Professor Bridgman, though separated by over 2000 years, are very much alike. The similarity shows a constancy in the human spirit and the quest for autonomy and dignity, existing long before and lasting long after our founding fathers incorporated this notion of liberty into the Constitution.

The cases before this Court involve, first and foremost, particular patients and their sacrosanct relationship with their caregivers. That that relationship serves the best interests of a patient, as well as society, is perhaps evidenced best by the graphic and compelling description of the death of an AIDS patient as recounted by his physician, one of the plaintiff physicians in *Compassion in Dying*:

One patient of mine ... lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his

bladder, his fingers gangrenous from clotted arteries. ... [F]riends stopped visiting him because it gave them nightmares. [The patient's] agonies could not be relieved by medication or by the excellent care he received. [He] begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that [the patient] was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the [State of Washington] statute, I was unable to assist him and he died after having been tortured for weeks by the end phase of his disease.

79 F.3d at 814. **American jurisprudence should not countenance suffering of this nature; an individual's Fourteenth Amendment liberty-rights do not allow for it.**

"Contemporary times demand contemporary, thoughtful and humane responses to the critical issue of terminally ill patients, not lock-step repetition of past follies." Smith, *supra* at 355. ACLM proposes such a contemporary, thoughtful and humane response.

Respectfully submitted,

AMERICAN COLLEGE OF
LEGAL MEDICINE

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APPENDIX A



Christine O. Gregoire

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October 18, 1996

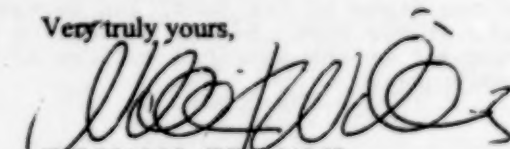
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**Re: *Washington v. Glucksberg*,
U.S. Supreme Court Cause No. 96-110**

Dear Mr. Zaremski:

This responds to your letter of October 14, 1996, requesting consent to file a brief as *amicus curiae* in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Very truly yours,



WILLIAM L. WILLIAMS
Sr. Assistant Attorney General

WLW:am

cc: Kari A. Smith

CONSENT TO FILING BRIEF AMICUS CURIAE

No. 95-1858

IN THE SUPREME COURT OF
THE UNITED STATES

October Term, 1995

DENNIS C. VACCO, Attorney General of the State of New York;
GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.;
and HOWARD A. GROSSMAN, M.D.,

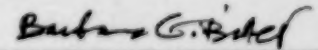
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

Consent to File Brief Amicus Curiae

Miles J. Zaremski, Esq.
Rudnick & Wolfe
203 North LaSalle St., Suite 1800
Chicago, Illinois 60601-1293

Pursuant to Rule 37, Petitioners Dennis C. Vacco, Attorney General of the State of New York, and George E. Pataki, Governor of the State of New York, hereby consent to the filing in this matter on behalf of the American College of Legal Medicine of a brief amicus curiae.


Barbara G. Billet
Solicitor General
State of New York
Office of the Attorney General
120 Broadway
New York, New York 10271



ROBERT M. MORGENTHAU
District Attorney

DISTRICT ATTORNEY
OF THE
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ONE HOGAN PLACE
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(212) 335-9000

October 17, 1996

Miles J. Zaremski
Rudnick & Wolfe
203 North LaSalle St. Suite 1800
Chicago, IL 60601-1293


Re: Vacco v. Quill
No. 95-1858

Dear Mr. Zaremski:

Pursuant to my conversation with Lucia M. Valente, Chief Special Counsel to the Attorney General of the State of New York, this confirms that District Attorney Robert M. Morgenthau consents to the appearance of the "American College of Legal Medicine" in the above matter as an amicus curiae under Rule 37.3(a). If you require such consent in a different form please so advise.

Respectfully,

Robert M. Morgenthau
District Attorney
New York County
One Hogan Place
New York, New York 10013
(212) 335-9000

By: 
Marc Frazier Scholl
Assistant District Attorney
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October 18, 1996

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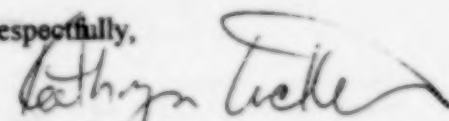
**Re: *State of Washington v. Glucksberg*, No. 96-110;
Amicus Participation**

Dear Mr. Zaremski:

This letter replaces the consent letter sent to you on October 16, 1996.

This responds to your letter of October 14, 1996 requesting consent to file a brief as amicus curiae in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Respectfully,


Kathryn L. Tucker

KAS:rak

cc: William L. Williams

APPENDIX A-4

[09901-7505/SL962900.200]

ANCHORAGE BELLEVUE HONG KONG LONDON LOS ANGELES OLYMPIA PORTLAND SEATTLE SPOKANE TAIPEI WASHINGTON, D.C.
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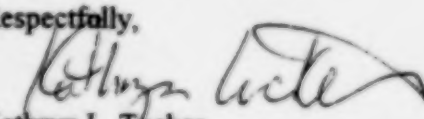
**Re: *Vacco v. Quill*, No. 95-1858;
Amicus Participation**

Dear Mr. Zaremski:

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This responds to your letter of October 14, 1996 requesting consent to file a brief as amicus curiae in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Respectfully,


Kathryn L. Tucker

KAS:rak

cc: Lucia M. Valente, Esq.

APPENDIX A-5

[09901-7505/SL962900.200]

ANCHORAGE BELLEVUE HONG KONG LONDON LOS ANGELES OLYMPIA PORTLAND SEATTLE SPOKANE TAIPEI WASHINGTON, D.C.
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APPENDIX B

State Statutes Governing Living Wills and Appointment of Health Care Agents



□ Jurisdictions with legislation that authorizes both living wills and the appointment of a health care agent (the District of Columbia and 45 states: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming).

▒ States with legislation that authorizes only living wills (2 states: Alabama and Alaska).

■ States with legislation that authorizes only the appointment of a health care agent (3 states: Massachusetts, Michigan and New York).

Note: The specifics of living will and health care agent legislation vary greatly from state to state. In addition, many states also have court-made law that affects residents' rights. For information about specific state laws, please contact Choice In Dying.

APPENDIX C

AMERICAN HOSPITAL ASSOCIATION

Policy and Statement

PATIENT'S CHOICE OF TREATMENT OPTIONS

POLICY

Health care decision making should be based on a collaborative relationship between the patient and the physician and/or other health care professionals who are primarily responsible for the patient's care.* The collaborative framework encourages communication, which contributes to sound decision making. Whenever possible, however, the authority to determine the course of treatment, if any, should rest with the patient, who may choose to delegate it. In the hospital setting, institutional methods should be established to reasonably assure that the patient may exercise this authority on the basis of relevant information necessary to make a sufficiently voluntary and informed decision. In addition, the health care institution should have methods to identify

*The term *physician* is used throughout the document, although other health care professionals may be responsible for or authorized to provide patient care.

This policy and statement was developed by the Special Committee on Biomedical Ethics, which had been established by the General Council in January 1983 to consider various aspects of biomedical ethical issues facing the health care field.

This document replaces the *Guidelines on the Right of the Patient to Refuse Treatment* that was approved in 1973. The House of Delegates approved the policy and statement in February 1985.

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circumstances under which the patient's authority may be constrained, and recourse to the judgment of others, including the courts, is appropriate.

STATEMENT

The right and responsibility to select among treatment options** presumes that the patient is capable of consulting with the physician about and understanding the available treatment alternatives and their implications and making a choice. Consultation might also take place with other responsible or authorized health care professionals involved in coordinating the patient's care. This process requires the patient's adequately-informed consent and may involve an evaluation of the patient's capacity to make a decision.

Collaborative Decision-Making

Informed consent should reflect shared or collaborative decision making by the patient and the physician. The physician should provide information on the patient's condition, the recommended procedure and/or treatment with its significant benefits and risks, the significant alternative for care or treatment (including no specific treatment), and the likely duration of incapacitation, if any.† Because patient's understanding of this information is essential to informed consent, care should be taken to present it in language familiar to them. Although institutional policy should promote documentation of consent decisions, such documentation is evidence of but not a substitute for communication and understanding between patient and physician. Unless the physician believes the patient would object, it may be advisable and

**For the purpose of this document, treatment can be interpreted to include diagnostic as well as therapeutic procedures.

†See the AHA Policy on *A Patient's Bill of Rights*.

useful if this information is shared with the patient's family, which often is a valuable resource for both the patient and the physician. Health care institutions and professionals should see to it that patients have access to understandable information relevant to the treatment choices before them.

In cases where the patient has chosen to delegate the treatment choice selection to the physician or someone else, a discussion with the patient about the implications and ramifications of the treatment course to be pursued is still recommended. Often family and friends should be included in this discussion.

In some emergencies, obtaining voluntary and adequately informed consent may not be possible or may be detrimental to the patient's well-being. In such cases, the patient's consent to the course of treatment chosen by a physician may be legally implied from the urgent circumstances surrounding the provision of that care.

Implications of Treatment Choice

The right to choose treatment includes the right to refuse a specific treatment or all treatment, or select an alternative form of treatment. If the patient decides to refuse all treatment, a written informed refusal is strongly recommended to protect the hospital, the physicians, and all other personnel from liability, if any, for failure to furnish treatment. This decision should also be documented on the patient's chart.

If a patient chooses a course of treatment that is not acceptable to the attending physicians or other health care professionals, those individuals may withdraw from the case, so long as doing so does not amount to legal abandonment. If a suitably qualified alternative physician or health care professional willing to comply with the patient's preference is available, transfer to the care of that individual should be offered to the patient. If no physician or qualified health care

professional is willing to undertake the patient's choice of treatment, the hospital should have a policy to address what procedures relative to care of the patient should be followed. The hospital also should have a policy to help identify and address those situations when the course of treatment selected is unacceptable to the mission of the institution.

Laws regarding the right of a patient or someone on the patient's behalf to refuse treatment vary from state to state. Some state laws limit a patient's right to refuse treatment, and others make provisions to facilitate the exercise of this right. The hospital's and the physician's response to a refusal, whether action or nonaction, must be consistent with applicable law. If a refusal can potentially result in substantial detriment to the patient's health and well-being, institutions should require that the appropriate administrative authority be informed. Protection of the patient's authority to select treatment at times may require either legal counsel or judicial proceedings.

Decision-Making Capacity

Decision-making capacity is the ability to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions. Attention should be paid to the difference between decision-making capacity and legal competency. Decision-making capacity may exist, as in the case of a minor, where no legal competency exists. Legal competency may exist where decision-making capacity does not, as in the case of a temporarily impaired adult who has not been deemed legally incompetent. In health care treatment decisions, decision-making capacity is best understood as the patient's ability to understand the nature and effects of treatment options, and appreciate the impact of a choice. Only when the patient's capacity to make decisions is definitely impaired and the effect of flawed decision making

is potentially serious should the patient's right and responsibility for decision making be transferred to others.

When there is reason to doubt the usual presumption of adequate decision-making capacity, an assessment of capacity is made by the physician in consultation with the family, friends, nurses, and other health care professionals. The institution should have effective policies to facilitate assessment of patients' decision-making capacity. The institution should have methods to ensure that the physician conducts these assessments when necessary. The hospital should also see to it that there are accessible and practical avenues by which concerns about a patient's capacity to make decisions may be raised by others, including family, friends, nurses, and other health care professionals. The hospital may also wish to have a policy under which a patient, in appropriate circumstances, should be informed both of any concerns raised by the assessment and of access to procedures for reassessment or to legal counsel. Only when the determination regarding decision-making capacity is controversial among concerned persons (including the patient) should legal guardianship proceedings be required.

When a patient lacks adequate decision-making capacity, substantial effort should be made to ensure that the choice of medical treatment is consistent with the known views of the patient. The decision makers must seek and take note of any information reflected in oral statements, life-style commitments, living wills, and so forth made by the patient before deterioration of decision-making capacity. These known views can sometimes be supplied by the family or an individual acting as surrogate. The surrogate should be a person or group of persons most likely to be able to advocate on the patient's behalf and to assess the patient's preferences and experiences. If the physician knows through informal communications, durable power of attorney, or living will of the patient's designation of a surrogate, that person should serve unless mitigating factors are apparent.

If the selection of the surrogate seems controversial, methods for institutional review and, if necessary, court adjudication are required. In some cases, court appointment of a surrogate may be legally required. The institution should be prepared to refer difficult cases to court for guardianship determinations.

Role of Minors in Decision-Making

Patients who are minors should be allowed to participate in decision-making about their care to the extent possible with regard to their capacity to understand treatment options and outcomes. When a minor is deemed legally incapable of making a decision, that is, not considered to be a "mature" or "emancipated" minor according to state law, the parent or legal guardian usually will have the final decision-making authority. Mature or emancipated minors, as determined by state law, should be treated as adults with decision-making capacity.

Institutions should establish policies concerning the circumstances under which legal advice is to be sought for either the institution or the minor, including cases where a parent or guardian makes a decision that may be deemed adverse to the interests of a minor or opposed to the expressed views of a relatively mature minor.

Management Practices and Procedures

Hospitals have a responsibility to assess the effect of management practices and procedures on patient decision-making options and to foster awareness among health care professionals and key hospital personnel that some institutional practices necessary to ensure efficiency, such as some admissions or food service procedures, can unintentionally limit patient choices. For example, the patient often does not have the opportunity to make many of the routine choices in day-to-day living—when to have meals, wake up, have visitors, etc.

Documentation of Decision-Making

Documentation of decisions regarding patient treatment promotes orderly procedures and more thorough consideration of options. Documentation also provides legal protection for and is often in the best interests of patients, patients' families, concerned health professionals, and hospitals.

Conclusion

The patients' role in determining the course of their medical treatment must be ensured in the institutional setting. Although these decisions should be made in collaboration with the attending physicians, the hospital must take a leadership role in ensuring institutional practices that support patients' decision making and in identifying when recourse to the judgment of others is necessary.